HHA PPS MAILBOX QUESTIONS
VOLUME X: October 2001 – Batch 1

The questions below, which in some cases have been paraphrased, were sent to *"e-mailto: HHPPS@HCFA.gov"* during the period referenced above. Due to low volume, the box was closed after this month. However, it is our intention to continue to answer questions that were received in monthly batches, until all questions received are answered, and post those answers at:

http://www.hcfa.gov/medlearn/refhha.htm

Subsequent billing questions should be directed to applicable Medicare Regional Home Health Intermediary [RHHI]. Provider contacts for the RHHIs are as follows:

Associated Hospital Services of Maine: http://www.ahsmedicare.com

Palmetto (South Carolina): http://www.PalmettoGBA.com
Click: Providers, then *Part A Intermediary/RHH*I, and then *contact us*

United Government Services (Wisconsin and California):
http://www.ugsmedicare.com/contact.html
(this will take providers directly to the contacts page of the UGS website)

Cahaba (Iowa): U*se the dedicate*d telephone inquiry line for HH Customer Service: **1-877-299-4500**

Note that the RHHIs continue to forward billing items needing national clarification to CMS. Contacts at CMS for other than billing issues continue to available for HH providers:

For policy/regulatory questions:
www.hcfa.gov/medicare/hhmain.htm#questions

For OASIS questions:
www.hcfa.gov/medicaid/oasis/hhqas.htm

To receive current information, join the CMS HH PPS mailing list:
www.hcfa.gov/medlearn/refhha.htm

Click on the link that says: *Join one of our Home Health Prospective Payment System mailing lists* and follow the instructions provided.

This batch of questions was pulled from the mailbox prior to November 1, 2001. Subsequent batches of answers will have to be released under the same Volume number (same month), so that internal experts can be consulted. Note that questions without broad applicability have been/will be answered/referred individually.

Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each batch of answers, and a table of cross-references will follow.

Questions by Major Topic

Alphabetical Cross-reference Topics

General Terms/Acronyms

The following terms/acronyms may not be spelled out/explained above or elsewhere in this document:

CMS = The Centers for Medicare and Medicaid Services, new name of HCFA (below).

FFS= Fee for service. Traditional method for health insurance payment, based on remitting a set fee for a service, rather beneficiary-based payment (i.e., capitation in an HMO)

Grouper= A software module in Medicare claim processing systems that groups information to determine payment on a claim

HAVEN= Medicare software supporting OASIS collection and transmission, also containing the grouper for HH PPS payment

HCFA = Health Care Financing Administration, previous name of the federal agency administering Medicare. Note: The name of the agency was changed to CMS.

HH = Home Health

HHA = Home Health Agency

HHRG = Home Health Resource Group, the payment group for HH PPS episodes

HIM 11 = Health Insurance Manual 11, the Medicare manual for HHAs.

HIPPS = Health Insurance PPS, a code representing a PPS payment group on a Medicare institutional claim, placed in Form Locator 44

LUPA = Low Utilization Payment Adjustment, a home health episode of four or fewer visits paid by national standard per visit rates.

OASIS = Outcome Assessment Information Set. The standard assessment instrument required by HCFA for use in delivering home care.

PPS = Prospective Payment System. A pre-determined method of fee for service payment of bundled services, as opposed to cost reimbursement of individual services, used to pay many types of Medicare providers (hospitals, SNFs, etc.); Medicare pays for home care under a plan of care through a PPS since October 1, 2000.

RAP = Request for Anticipated Payment. The first of two transactions submitted on a UB92 claim form to get the first of two split percentage payments for a HH PPS episode.

RHHI = Regional Home Health Intermediary. Medicare **fiscal intermediary** specializing in the processing of hospice and home health claims.

"RTP'd"= A unprocessed transaction sent back to providers by RHHIs

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OCTOBER

RATES and PAYMENT

Q1. In your HH PPS Questions and Answers, Volume 1, January 2001, Batch 3, Q5, A5, you updated a comment in August 2001 stating that a situation where a patient was discharged and then readmitted within a time period within the 60 day episode, that the prior discharge is PEP'ed and the readmission date becomes the first day of a new episode. Must the agency bill this way? For example, we had a patient in that situation receiving daily heparin injections for a leg blood clot. The problem resolved and injections were discontinued after 7 visits, there were no other skilled needs and the patient was discharged. However, the patient was readmitted 2 weeks later with a reoccurrence of the blood clot, and received 3 daily injections, then was hospitalized and did not return to services. Previously we understood that in such a situation, this would be a SCIC, which we did not bill as the result was a lower payment where the HIPPS code did not change (same condition and same score). However, in the situation you describe, we would now receive 7/60th of an episode for the first period and a LUPA for the second, which no longer results in a full episode payment. Since we treated this as a SCIC that was not billed, must we now go back and change this to a discharge with a new episode (along with OASIS corrections and OASIS resubmission)?

A1. There is a difference in answer for the two different scenarios cited. One, in the question above, where it appears discharge occurs specifically because treatment goals were met; and two, the January Q&A cited, where it is not clear goals are met, and discharges "for whatever reason" are the question. If discharge is clearly because goals are met, a PEP would be the appropriate billing. This policy is codified in recently published updates to the Home Health Agency Manual (Publication 11; 2001 Transmittal #298), in the beginning of Section 201.8, available on the CMS web site.

When is discharge is not clearly being done because treatment goals are met, billing a SCIC is usually preferable, rather than having two episode payments made. Ideally, episodes are continuous 60-days periods that are contiguous, or in sequence in time, without any gaps, for all home care for patients receiving continuous care from a primary HHA.

CMS realizes this can be a fine line. Mindful of provider burden, CMS will permit prior episodes to stand, pending PEP adjustment by Medicare systems, if patients unexpectedly return in the same 60-day period, whether goals have been have been met or not. Even when a PEP has already been billed, HHAs may instead decide to cancel the prior claim and re-bill the episode for the continuous 60-day period. This approach may especially make sense if the patient has returned for treatment similar to that covered in the original plan of care, and care did not exceed a total of 60 days.

Q2. When do I bill for a significant change in condition for a patient?

A2. This question has been raised many times, including in other questions on this site. In a single sentence, you must bill for a SCIC adjustment when there is a unanticipated change in patient condition necessitating: (1) new orders, and (2) re-assessment of the patient, that results in a change to the HIPPS code billed on the RAP, other than: (1) a sole change in number of therapies affecting only the therapy threshold (change to/from fallback HIPPS), and if: (2) the change to the HIPPS code represents more intensive services/a worsening patient condition, and (3) billing this additional HIPPS does not result in the HHA receiving less reimbursement for caring for this sicker patient than if the agency did not bill the additional HIPPS for this change. CMS is considering posting a graphic presentation of this logic on this website. Two brief examples:

(1) If original HIPPS code is HAEK1, and the new HIPPS code is HAEJ1, a SCIC does not have to be billed, since this is not a change in the payment group of the patient, but only a change in the version of the HIPPS reflecting whether or not the therapy threshold was met.

(2) If original HIPPS code is HDHM1, and the new HIPPS code is HAEL1, a SCIC does have to be billed, since this change apparently represents an

improvement in patient condition not anticipated in the plan of care that signifies fewer resources are needed to treat the patient.

CLAIMS, ELEMENTS AND CODING

Q3. We have a question regarding our responsibility for identifying changes in the anticipated number of therapy visits in an episode. For example, if in submitting the RAP, we have anticipated that the patient will receive 10 or more therapy visits, but at the end of the episode, the number of visits was actually below 10, what action should we take in submitting the final claim? Currently, CMS is downcoding, this but do we now or will we in the future have a responsibility to identify and adjust these prior to submitting the final claim? If we will in the future, what is the timeframe for this?

A3. CMS has no plans to change the automatic downcoding to support enforcement the therapy threshold. As long as the plan of care used to bill the RAP supports the billing of the higher therapy level, no integrity issues arise if it turns out a patient actually needs for fewer services than the plan of care anticipated, and were subsequently billed on the claim. Patterns that suggest patients are being underserved, if substantiated, become survey and quality of care issues. At this point in time, if CMS did decide to change a basic element of HH PPS billing such as the automatic enforcement of the therapy threshold, providers would be given substantial advance notice through revised CMS instructions, RHHIs bulletins and websites.

Q4 (First of two parts from this inquirer). An HHA has signed physician orders for a plan of care (POC). However, a modified verbal order was issued for which a signature for the additional visit(s) or additional discipline(s) cannot be obtained. For example, the HHA ordered a social worker to assist with long term care planning. Can the HHA, as described in the situations above, submit a Final Claim for the episode? If so, should the visits that are part of the unsigned order be included? Should the Final Claim be submitted without the additional visits/disciplines included?

A4. In the case described above, as suggested in the question, it is correct that a claim can be filed when signed orders for only part of the services in the episode have been obtained, but the claim cannot contain services not supported by signed orders. It is the option of HHAs in this situation which of the following two options they prefer: (1) file the claim without the services without signed orders, and later adjust the claim when the signed orders are obtained; or (2) do not file the claim until all orders have been signed for all services in the episode period. Claims can be filed and adjusted for the entire timely filing period, which is 15-27 months depending on the month in which the services are delivered. All claims may be filed up to the end of the calendar year following the year in which the services are delivered, and claims for services delivered in the last quarter of the calendar year may be filed up until the end of two calendar years after the year in which the services were delivered.

Q5. Can you clarify one more time the rule in regard to sequential billing and overlapping episodes? For example: I have a patient with an episode that started 01/01/01, and the patient remains on service presently (10/12/01). I have RAPs in suspense for 8/01, 9/01 and an end of episode claim that was returned (RTP'ed) for 5/01 for this same patient, and I want to send a RAP for 01/01 that was previously auto-canceled. Can I submit this RAP (01/01) for payment without having to recall subsequent episodes (paid and unpaid) for this patient?

A5. Yes, in the example above, the RAP can be re-submitted without having to change or cancel subsequent billings. While a claim, except a no-RAP LUPA claim, will be returned if there is no RAP to support it, since a RAP and a claim must be sequential within an episode, each episode is independent from other non-overlapping episodes. That is, even if a RAP for a prior episode in a period of continuous care was auto-cancelled, so that when the claim for the same episode was submitted it was also returned, RAPs, and claims for subsequent episodes, can still be submitted, and nothing need be changed, as long as none of the episodes overlap. In re-submitting the RAP, subsequent episodes would only be affected if the length of the episode being billed changed in a manner overlapping or affecting other episodes.

Note a no-RAP LUPA is a claim for an episode known to be a LUPA from the outset, and therefore just a LUPA claim can be billed without a RAP, though RAPs can still be billed for LUPAs if providers prefer to do so. This is the only case in which a RAP is not required before a claim in an episode.

OASIS

Q6. What is the procedure for billing home care services for a patient under 18 years of age who is Medicare primary? No OASIS data is collected according to the regulations.

A6. There is no way to bill Medicare for HH PPS payment without a payment group, represented by a HIPPS code or HHRG, produced by inputting an OASIS assessment into Grouper software (embedded in HAVEN or a comparable product of your software vendor). Therefore, such patients must be assessed if Medicare if is to be billed. Such assessments, however, would not be transmitted to the States, and claims for these beneficiaries would not have a true Claim-OASIS matching key placed on Form Locator 63 of the RAP or claim. Instead, all eighteen characters of this field should be filled with the number "1", signaling no assessment was transmitted to the State to match to this episode. Regarding such requirements for billing, CMS is still in the process of putting out these instructions, but clarification will be included in revised instruction put out in 2002.

Q7 (Second part of one question from this inquirer). Some billing solutions provided by our RHHI and CMS conflict with OASIS regulations. Is there an entity or person with whom we can deal to ensure that when we are given a directive by either the State or

CMS, one is in compliance with the other? At the present, we may be given a billing directive that we cannot implement due to its conflict with OASIS regulations. For example, CMS instructs, on Volume VI: June 2001 - Batch 1, that the HHA should utilize the most recent OASIS in the event that FFS Medicare is determined after the fact to be the primary payer. We are concerned that OASIS regulations may be in conflict with this directive.

A7. CMS does not know of any conflicts between OASIS and billing instructions. However, the answer to Question 6 in the June batch of Q&As cited was not clearly worded, particularly in its use of the word "recent", and this answer will be revised. The answer still does contain the correct policy: "to the greatest degree possible, the OASIS should assess an actual or current patient, not a reconstruction of a patient from memory"; in other words, that the OASIS assessment done closest in time to the episode period being billed should be used in cases when an assessment was not done timely. In general, RHHIs should be called if a specific conflict between OASIS and billing instructions is found. The RHHI will contact CMS and States as necessary. CMS does try to avoid conflicts of the type suggested, as do the States, and will appreciate being apprised of any oversights.